		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033035

Facility Name: Clearbrook West

Address: 3980 Fairfax (Number) Rolling Meadows (City) 60008 (Zip Code)

County: Cook

Telephone Number: 847-870-7711 **Fax #** 847-870-9926

IDPA ID Number: 36-2420176-003

Date of Initial License for Current Owners: 01/31/89

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501C3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kathleen Appleton **Telephone Number:** 847-870-7711x240

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/99 to 6/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Carl La Mell
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,259			5,259	13
14	TOTALS	5,259			5,259	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.05%

D. How many bed-hold days during this year were paid by Public Aid?
581 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 01/01/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 7/1/99 Fiscal Year: 6/30/00

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	18,372			18,372		18,372		18,372			1
2	Food Purchase		46,224		46,224		46,224		46,224			2
3	Housekeeping		3,108		3,108		3,108		3,108			3
4	Laundry											4
5	Heat and Other Utilities			12,041	12,041		12,041		12,041			5
6	Maintenance	12,475	2,865	26,320	41,660		41,660	3,204	44,864			6
7	Other (specify):*											7
8	**TOTAL General Services**	30,847	52,197	38,361	121,405		121,405	3,204	124,609			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	263,812	3,202		267,014		267,014		267,014			10
10a	Therapy											10a
11	Activities		1,176		1,176		1,176		1,176			11
12	Social Services											12
13	Nurse Aide Training											13
14	Program Transportation			196	196		196		196			14
15	Other (specify):* Program consultants			70,694	70,694		70,694		70,694			15
16	**TOTAL Health Care and Programs**	263,812	4,378	70,890	339,080		339,080		339,080			16
	C. General Administration											
17	Administrative	25,578			25,578		25,578	17,671	43,249			17
18	Directors Fees											18
19	Professional Services							2,726	2,726			19
20	Dues, Fees, Subscriptions & Promotions			286	286		286	1,109	1,395			20
21	Clerical & General Office Expenses		539		539		539	12,849	13,388			21
22	Employee Benefits & Payroll Taxes			52,315	52,315		52,315	7,768	60,083			22
23	Inservice Training & Education							5,852	5,852			23
24	Travel and Seminar			469	469		469		469			24
25	Other Admin. Staff Transportation							548	548			25
26	Insurance-Prop.Liab.Malpractice			7,318	7,318		7,318	628	7,946			26
27	Other (specify):* See page 24			9,252	9,252		9,252		9,252			27
28	**TOTAL General Administration**	25,578	539	69,640	95,757		95,757	49,151	144,908			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	320,237	57,114	178,891	556,242		556,242	52,355	608,597			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Clearbrook West #0033035 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			23,685	23,685		23,685		23,685			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,621	44,621		44,621	1,216	45,837			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			68,306	68,306		68,306	1,216	69,522			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,100	35,100		35,100		35,100			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			35,100	35,100		35,100		35,100			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	320,237	57,114	282,297	659,648		659,648	53,571	713,219			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Clearbrook West

ID# 0033035

Report Period Beginning: 7/1/99

Ending: 6/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	0		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Clearbrook West** **#** **0033035** **Report Period Beginning:** **7/1/99** **Ending:** **6/30/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**TOTALS (to Sch V, col.7)**	
30	Depreciation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**32**
33	Real Estate Taxes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**34**
35	Rent-Equipment & Vehicles	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**
36	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**36**
37	**TOTAL Ownership**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**38**
39	Ancillary Service Centers	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**39**
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**40**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**41**
42	Provider Participation Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**
43	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**
44	**TOTAL Special Cost Centers**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**45**

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	0.00%	Clearbrook - Lattof Commons	Rolling Meadows	Clearbrook	Rolling Meadows	Not for profit
None	0.00%	Clearbrook West	Rolling Meadows	CRH, Inc.	Rolling Meadows	Not for profit
None	0.00%	Clearbrook East	Rolling Meadows	Clearbrook	Rolling Meadows	Not for profit
None	0.00%	Wright Home	Gurnee	Augustana	Rolling Meadows	Not for profit

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Program costs	15,114,878		$ 86,744	$	558,234	$ 3,204	1
2	17	Administrative	Program costs	15,114,878		478,478	478,478	558,234	17,671	2
3	19	Professional services	Program costs	15,114,878		73,812		558,234	2,726	3
4	20	Fees, subscriptions and dues	Program costs	15,114,878		30,022		558,234	1,109	4
5	21	Clerical and general	Program costs	15,114,878		708,925	347,904	558,234	12,849	5
6	22	Employee benefits	Program costs	15,114,878		210,332		558,234	7,768	6
7	23	In service training and education	Program costs	15,114,878		158,460	104,930	558,234	5,852	7
8	25	Other admin transportation	Program costs	15,114,878		14,835		558,234	548	8
9	26	Insurance	Program costs	15,114,878		17,005		558,234	628	9
10	32	Interest	Program costs	15,114,878		32,937		558,234	1,216	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,811,550	$ 931,311		$ 53,571	25

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD		X	Construct building	$3,839.00	01/01/89	$ 497,600	$ 472,028	11/01/28	9.0000	$ 42,571	1
2	Harris Bank		X	Vehicle	$692.74	04/01/98	33,193	20,293	04/01/04	8.6500	2,050	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$4,531.74		$ 530,793	$ 492,321			$ 44,621	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 530,793	$ 492,321			$ 44,621	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Clearbrook West **#** 0033035 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,216 B. General Construction Type: Exterior Aluminum Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building	36,839	1986	$ 87,000	1
2					2
3	TOTALS	36,839		$ 87,000	3

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1989	1989	$ 495,998	$ 13,301	40	$ 13,301	$	$ 143,501	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler System			1989	7,797	211	37	211		2,213	9
10	Sprinkler system			1990	1,729	47	37	47		491	10
11	Protective wall covering			1993	2,480	71	35	71		531	11
12	Garage addition			1994	5,740	169	34	169		1,097	12
13	Bathroom remodeling			1998	7,726	818	10	818	(0)	1,591	13
14	Carpet			1996	4,876	488	10	488		2,194	14
15	Roof			2000	9,240	308	15	308		308	15
16	Fairfax kitchen remodeling			2000	10,717	214	25	214		214	16
17	Fairfax bathroom improvements			1999	9,043	624	15	624		624	17
18	Fairfax bathroom improvements			2000	2,319	77	15	77		77	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 557,664	$ 16,327		$ 16,327	$ (0)	$ 152,841	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 14,687	$ 1,519	$ 1,519	$	10-Jan	$ 7,482	37
38	Current Year Purchases	2,334	233	233		10	233	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 17,021	$ 1,752	$ 1,752	$		$ 7,715	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient care	1997 Dodge Braun	1998	$ 33,643	$ 5,606	$ 5,606	$		$ 14,018	42
43										43
44										44
45										45
46	TOTALS			$ 33,643	$ 5,606	$ 5,606	$		$ 14,018	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	695,328	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	23,685	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	23,685	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	(0)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	174,575	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 44

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	14

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 374,296	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		2,060,227	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		88,017	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		107,677	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from temporarily restricted		876,269	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 3,506,486	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,385,317	13
14	Buildings, at Historical Cost		13,487,032	14
15	Leasehold Improvements, at Historical Cost		277,881	15
16	Equipment, at Historical Cost		3,290,913	16
17	Accumulated Depreciation (book methods)		(6,133,869)	17
18	Deferred Charges		242,261	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits		115,896	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 12,665,431	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 16,171,917	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 442,596	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		525,863	29
30	Accrued Salaries Payable		777,784	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		18,531	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See page 25		200,142	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 1,964,916	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,640,727	40
41	Bonds Payable		3,700,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to permanently restricted		536,523	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,877,250	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 8,842,166	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,329,751	$ 7,329,751	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,329,751	$ 16,171,917	48

***(See instructions.)**

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,978,009	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,978,009	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	61,491	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Consoldated net income of West**	290,251	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 351,742	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,329,751	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 610,090	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 610,090	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	99,772	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 99,772	23
	D. Non-Operating Revenue		
24	Contributions	10,577	24
25	Interest and Other Investment Income***	700	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,277	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 721,139	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	121,405	31
32	Health Care	339,080	32
33	General Administration	95,757	33
	B. Capital Expense		
34	Ownership	68,306	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	35,100	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 659,648	40
41	**Income before Income Taxes (line 30 minus line 40)****	61,491	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 61,491	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.** **Consolidated with our other programs**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,400	1,506	21,129	14.45	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,019	2,172	18,372	8.46	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	916	985	12,475	12.66	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	460	495	14,413	29.12	20
21	Assistant Administrator					21
22	Other Administrative	400	431	14,691	34.09	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,007	2,158	24,428	11.32	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	21,505	23,124	205,802	8.90	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Coordinator	504	542	8,927	16.47	33
34	TOTAL (lines 1 - 33)	29,211	31,413	$ 320,237 *	$ 10.19	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$	See Clinic	35
36	Medical Director			Schedule	36
37	Medical Records Consultant	4	213		37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	390	8,196		40
41	Occupational Therapy Consultant	905	34,422		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	361	13,357		43
44	Activity Consultant				44
45	Social Service Consultant	780	13,253		45
46	Other(specify) Psychiatric	263	19,725		46
47	Medical doctor		24,000		47
48	Neuroligical & Behavorial	357	10,787		48
49	TOTAL (lines 35 - 48)	3,060	$ 123,953		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Susan Kaufman	Vice President	0.00	6,485
Joe Lawler	Administrator	0.00	19,093
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 25,578

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 2,475
Unemployment Compensation Insurance	1,610
FICA Taxes	24,178
Employee Health Insurance	15,879
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Annuity	8,173
Staff Education Grants	
Allocated Schedule VII Row 6, Column 9	7,768
TOTAL (agree to Schedule V, line 22, col.8)	$ 60,083

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Subscriptions	286
Allocated Schedule VII Row 4, Column 9	1,109
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,395

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Staff conferences	469
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 469

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Clearbrook West # 0033035 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Clearbrook West # 0033035 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 330 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 35,100
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ None Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Blackman Kallick Bartelstein The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain. Yes

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Schedule V Line 6 Maintenance other

Communications	10,105
Postage & Shipping	0
FF&E repairs and maintenance	664
Vehicle repairs and maintenance	2,072
Care of building and grounds	9,969
Trash removal	2,237
Miscellaneous rent	1,274
	26,321

Schedule V Line 15 Other

Total clinic costs		
Consultants (see schedule VIII B Consultant Service)		123,953
Salaries/wages		324,661
Other Clinic costs		90,433
		539,047
Less allocation to CILA clients		(25,105)
		513,942
Allocation based on total clients served		
Clearbrook Commons	92	381,312
Clearbrook East	16	66,315
Clearbrook West	16	66,315
	124	513,942
Clinic		66,315
Drugs		673
Nursing		192
Denistry		657
Vision		0
Dietician		2,615
Other medical		242
		70,694

Schedule V Line 27 Other

Specific assistance to individuals	1,853
Gas and Oil	1,442
Other professional fees-Dept of Public H	433
Audit fees	3,750
Staff educational grants	1,200
Moving and recruiting	249
Staff medical exams	205
Bank and brokerage fees	25
Miscellaneous	95
	9,252

Schedule VIII Line 3 Professional services

Audit fees	31,589
Legal fees	13,966
Computer consulting fees	5,958
Payroll processing	21,576
Temporary help	230
Accreditation	60
Trust fees	433
Accounting fees	0
Administrative consulting	0
	73,812

Schedule VIII Line 7 Inservice training	Clearbrook Total
Salaries	104,930
Employee benefits	17,698
Occupancy	22,274
Insurance	639
Special events and activities	5536
Other	7,383
	158,460

Clearbrook ID # 0030023/0033027/0033035/0037820

Reconciliation of cost reports to audit

Cost reports			
Clearbrook East			739,152
Clearbrook West			659,647
Clearbrook Center			4,283,829
Augustana Group Home			980,848
			6,663,476
Less provider tax included in revenue in audit			(348,684)
			6,314,792
Audit			
ICF			5,803,351
Subtract expenses related to special grant money			(2,500)
Clinic net of allocation to CILA	539,047	-25105	513,942
			6,314,793

Schedule XV Balance Sheet/Schedule of changes in equity

These statements are prepared on a consolidated basis on the Unrestricted Fund per the audit. We do not maintain separate balance sheets per program.

Schedule XV Balance Sheet Other current liabilities

Deferred revenue	79,257
Due to related parties	60,000
Due to government agencies	38288
Other liabilities	12,178
Other accrued expenses	10,419
	200,142

Clearbrook
ID # 0033035/0033027/0030023

Schedule V Line 15 Clinic salaries

BALMECEDA, DOMICIANO	Behavior therapist	26,203
BELL,PATRICIA	Behavior	29,110
CAMPUZANO,HELEN M	Speech	17,971
CRANE,LISA	Physical therapy	41,431
GRUENFELD, ROBIN	Habilitative aide	11,757
HOPKINSON,JUDITH	Social worker	1,779
LEW, LISA	Program director	20,957
MORGAN, ALICE	Secretary	13,003
MURRAY,CAROL	Speech	52,786
RAINEY,AFRICA	Clerical	24,784
SCHREINER, LAURA	Clerical	27,430
SHEEHAN,KIM	Physical therapy	21,556
STROM, JENNIFER	Occupational therapist	502
WRONKE,KATHLEEN	Physical therapy	41,309
		330,578
	Allocated elsewhere	(5,917)
	Total salaries of clinic	324,661

Schedule VIII Line 2 and 21 Salaries

NAME	TITLE	SALARY
APPLETON,KATHLEEN	VICE PRESIDENT-FINANCE	85,708
BAEZ-LOPEZ,ROSA	VICE PRESIDENT-HUMAN RESOURCE	63,630
BELLOMO,STACEY A.	PROGRAM COORDINATOR	52,000
FRICK,DONALD LEE	MIS	62,478
LA-MELL,CARL	PRESIDENT	131,300
TURI,JAMES A	VICE PRESIDENT-BUS OPERATIONS	83,361
		478,478
ANDERSEN,BERNADETTE	ADMINISTRATIVE ASSISTANT	35,977
WEBER, KATHLEEN	PAYROLL	12,184
CALDERON,TANIA	ADMINISTRATIVE ASSISTANT	27,530
CHEN, KENNETH	DATA ADMINISTRATOR	40,462
COPELAND,ELIZABETH	RECEPTIONIST	15,540
KAUFMAN,JOYCE	CLERICAL-HR	31,904
LOMBARDI,ANITA N	PAYROLL	36,333
PAULS,LESLIE	ACCOUNTANT	34,000
RIX,JOHN	CLERICAL-AR	27,192
ROBINSON,DENISE	ADMINISTRATIVE ASSISTANT	28,096
TALAGA,ROSEMARY	CLERICAL-AP	24,298
WILCOXSON,TONYA	CLERICAL-AR	34,387
		347,904